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February 23, 2004

Marlene H. Dortch
Secretary
Federal Communications Commission
445 12th Street, SW
Washington, D.C. 20554

Re: In the Matter of Rural Health Care Support Mechanism
WC Docket No. 02-60

Dear Secretary Dortch:

I am writing in support of an urgently needed change to the Commission's rural health care support mechanism. Specifically, the current definition of "rural" needs to be expanded to cover communities that are distressed, mountainous, have low population density, and suffer from shortages in health professional services notwithstanding their inclusion in federally drawn metropolitan statistical areas (MSAs). The Commission's current definition of "rural" is too restrictive and undermines progress achieved in its recent *Report and Order* designed to release funds for rural health care providers.[1] The definition currently used by the Commission disqualifies communities that are considered rural under other well-established state and federal agency programs. In these Comments, I examine definitions used by other agencies and set forth a proposed definition for the Commission to adopt for purposes of the rural health care support mechanism.

As a representative of a district, which is home to 49 telemedicine sites, I have first hand knowledge of the positive effects telemedicine programs can have on rural communities. All too often, rural residents cannot afford to travel a great distance to specialized medical care facilities. They, accordingly, have historically suffered from lack of access to timely medical care. Many rural residents are now relying on telemedicine to receive medical services, particularly specialty care. The funding

[1] *See In the Matter of Rural Health Care Support Mechanism,* WC Docket No. 02-60, FCC 03-288, Report and Order, Order on Reconsideration, and Further Notice of Proposed Rulemaking, 18 FCC Rcd 24556 (rel. Nov. 17, 2003) (hereinafter "*Report and Order*").

provided by the rural health care support mechanism is crucial to the sustainability of telemedicine programs, and, consequently, critical to the provision of access to health services to the underserved rural populations of our nation.

A greater utilization of the rural health care support mechanism will provide a wide variety of additional benefits to rural communities and the nation as a whole. Support for broadband services for rural health care providers leads to the development of a broader and more fully integrated network of health care providers across the nation. It also encourages greater deployment of broadband facilities, provides educational programs for health professionals, and establishes a front-line defense against a bioterrorist attack or other health-related disaster.[2] The Commission's recent *Report and Order* recognized these benefits of telemedicine programs and accordingly reexamined and improved its rural health care support mechanism program.[3]

I. The Commission's Currently Used Definition of "Rural" Is Flawed in Several Respects.

A. The Commission's Definition of "Rural" Has Yielded Anomalous Results and Excluded Areas That Should Be Considered Rural Under Any Common Sense Definition.

The Commission's current definition of "rural," which is based on census statistics, often fails to include communities that undoubtedly should qualify for support. Unfortunately, many areas in my District that are mountainous and sparsely populated, while qualifying as distressed or rural under other federal agency programs, are encompassed within MSAs and are, therefore, *not* considered as "rural" for purposes of the Commission's rural health care support program. Accordingly, these communities, which suffer from health-care shortages, do not qualify to receive the discounted telecommunications and information services that are necessary for telemedicine programs to survive. Without affordable broadband connectivity, these programs may falter, and fewer new networks will develop, let alone flourish.

One such example of an area that strangely does not qualify under the Commission's definition of "rural" is the small town of Dungannon, located in Scott County, Virginia. Dungannon has a total population of 311 persons. The town is surrounded by the Appalachian Mountains and is not easily accessible by any major highways. The population density of the entire county in which Dungannon is located is only 44 persons per square mile. The town does not have a hospital. In fact, the entire

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[2] *See* Letter to Marlene Dortch, Secretary, Federal Communications Commission, from Rep. Boucher, dated July 31, 2002, re: *In the Matter of Rural Health Care Support Mechanism*, WC Docket No. 02-60.

[3] The *Report and Order* states: "The actions we take today will also strengthen telemedicine and telehealth networks across the nation, help improve the quality of health care services available in rural America, and better enable rural communities to rapidly diagnose, treat, and contain possible outbreaks of disease. Moreover, enhancing access to an integrated nation-wide telecommunications network for rural health care providers will further the Commission's core responsibility to make available a rapid nation-wide network for the purpose of the national defense, particularly with the increased awareness of the possibility of biological or chemical terrorist attacks." *Report and Order*, 18 FCC Rcd 24556 at ¶ 2.

county is without a hospital. Therefore, to receive medical services, the citizens of Dungannon rely heavily on the telemedicine facilities at the Clinch River Health Services Clinic located within the town. The only other option for Dungannon residents is to drive 26 miles through mountains, on a narrow road, to the nearest hospital. The region in which Dungannon is located is considered a health professional shortage area by the Bureau of Primary Health Care.[4] Additionally, the town has been labeled "extremely rural" according to the United Stated Department of Agriculture standards[5] and is considered a rural, transitional area according to standards established by the Appalachian Regional Commission.[6]

Despite the obvious indicators that the small town of Dungannon is mountainous, has a low population density, and is a federally qualified rural and health professional shortage area, the medical clinic in this town *does not qualify* for funds under the Commission's rural health care support mechanism program because it is appended to an MSA. As a result, the telemedicine site in Dungannon must pay up to three times more for high-speed broadband connections, such as T-1 services, than sites located in neighboring counties, which qualify under the Commission's program.

Giles County, Virginia, also located in my Congressional district, similarly illustrates the flaws of the current definition of "rural." The only hospital in the entire county, Carilion Giles Memorial Hospital, which is a not-for-profit federally designated critical access hospital, no longer qualifies for funding because the county is now considered "urban" according to the 2000 census statistics. Giles County is anything but urban. Giles County is bordered by Appalachian Mountains and has a low population density of 47 persons per square mile. If a family is in need of emergency services, it can either go to the Carilion Hospital or drive through mountainous terrain to Blacksburg, Virginia, 24 miles away. The Appalachian Regional Commission has identified Giles County as a rural, transitional county.

The actual increase in population size for Giles County between 1990 and 2000 was only 291 persons, clearly not enough under any reasonable standard to disqualify this community from receiving rural support. However, the 2000 census redefines Giles County as "urban" because of its proximity to the Blacksburg-Christinasburg-Radford, Virginia Metropolitan Statistical Area. As a result, Carilion Giles Memorial Hospital, which provides much-needed emergency medical services to an isolated, underserved area, will now have to pay exorbitant costs for its telemedicine broadband connectivity because under the Commission's current definition of "rural" it is no longer eligible for rural health care support. Despite the fact that all signs indicate that this community is rural, the Commission's current program prohibits the Giles telemedicine service from qualifying for any discounts.

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[4] *See* 42 U.S.C. § 254(e).
[5] *See* 7 C.F.R. § 1703.126.
[6] *See generally* 40 U.S.C. § 14101 *et. seq.* (sets forth the establishment and purpose of Appalachian Regional Commission and its telecommunications program). *See also* http://www.arc.gov/search/method/cty_econ.jsp for an explanation of the Commission's classification system.

These are only two examples of many more that I could provide from my district that underscore the need for an expansion of the Commission's current definition of rural, which excludes areas that clearly are isolated, mountainous, and in need of professional health services.

B. The Commission's Definition of Rural Needs To Be Expanded To Fulfill Congressional Expectations.

In order to fulfill expectations for the rural health care universal service support system as envisioned by Congress, the definition of "rural" should be expanded to include areas such as Dungannon and Giles County. The universal service support system, as set forth in Section 254 of the Communications Act, directs the Commission to ensure that health care providers serving rural communities *not pay more* than their urban counterparts for their telecommunications needs.[7] Additionally, it requires the Commission to enhance access to advanced telecommunications and information services for *all* health care providers.[8]

Dungannon and Giles County have health care providers that serve mountainous, low-population areas that are considered rural by many agencies, such as the Appalachian Regional Commission and the United States Department of Agriculture, but under the current Commission regime, these communities *must pay more than their urban counterparts*. This outcome clearly frustrates Congressional intent.

Modifying the Commission's definition will ensure that the goals of Congress will be met. Maintaining the current definition will only increase the isolation of rural areas in direct contravention of the express goals of Section 254. To meet Congressional expectations, the Commission needs to expand its definition of rural by considering definitions used by other agencies and by taking into account population density and health shortages. By doing so, the Commission will fulfill the principles of the universal service program and increase access to medical services in underserved areas.

C. The Commission Mistakenly Relies Solely on the Census Bureau and Office of Management and Budget's Definition of Rural.

A review of the Commission's current definition of rural reveals that it is outdated and was never particularly well-suited to the needs of the universal service rural health care support mechanism. The Commission currently defines a rural area as a:

> nonmetropolitan county or county equivalent, as defined in the Office of Management and Budget's (OMB) Revised Standards for Defining Metropolitan Areas in the 1990s and identifiable from the most recent Metropolitan Statistical Area (MSA) list released by OMB, or any contiguous non-urban Census Tract or Block Numbered Area within an

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[7] *See* 47 U.S.C. § 254(h)(1)(A).
[8] *See id.* at § 254(h)(2).

MSA-listed metropolitan county identified in the most recent Goldsmith Modification published by the Office of Rural Health Policy of the U.S. Department of Health and Human Services.[9]

This definition is outdated because of its reliance on the Goldsmith Modification from the 1990 Census Data, which is more than 10 years old. The Goldsmith Modification will not be updated to the most recent 2000 Census Data because it is not even in use by the agency that created it, the Office of Rural Health Policy (ORHP). The ORHP recognized a need for change and decided to abandon the outmoded Goldsmith Modification — so should the Commission.

Furthermore, the general reliance on the OMB and Census Bureau as a litmus test for determining the rural nature of an area is misguided and not well-suited to determining the funding needs for broadband services for rural telemedicine programs. The Census Bureau and OMB never intended for the Commission to adopt its rural/urban methodology. On the contrary, both agencies warned against potential problems that can result when an agency relies on a definition that was originally designed for demographic measurement and projection. For example, the OMB warned against using Metropolitan and Micropolitan Statistical Areas as a measurement for program needs because they do not necessarily equate, by themselves, to urban-rural classifications.[10]

More specifically, the OMB stated that its measurements should not serve as a framework for nonstatistical activities and *may not* be suitable for use in program funding formulas.[11] The OMB reasoned that "[p]rograms that base funding levels or eligibility on whether a county is included in a Metropolitan or Micropolitan Statistical Area may not accurately address issues or problems faced by local populations."[12] The OMB urged "agencies, organizations, and policy makers to *review carefully* the goals of non-statistical programs and policies . . . [for programs] . . . used to determine eligibility for and the allocation of federal funds."[13]

I urge the Commission to heed the OMB's cautionary statements and review carefully its reliance on the OMB and Census Bureau as the basis for its funding program. Under the current OMB/Census-based definition, the principles of the universal service health care program are not being fulfilled. Accordingly, the Commission should steer away from this restrictive definition and expand the meaning of "rural." Doing so will provide much-needed access to affordable broadband connectivity to underserved communities that in fact are very rural.

Although the Commission should not rely solely on the OMB and the Census Bureau as the basis for its definition, the non-MSA provision of the Census Bureau's

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[9] 47 C.F.R. § 54.5.
[10] *See Standards for Defining Metropolitan and Micropolitan Stations Areas,* 65 Fed. Reg. 82228-29 (Dec. 27, 2000).
[11] *See id.*
[12] *Id.*
[13] *Id* (emphasis added).

Order does provide a solid basis for a *component* of the Commission's newly expanded definition. A non-MSA area is, in most cases, an area that is unlikely to be urban and thus likely to be rural. In other words, although the non-MSA test is underinclusive, it provides a useful starting point.

As discussed below, the Commission should supplement its MSA-related definition with a test focusing on three additional factors. First, the Commission should consider defining communities with fewer than 20,000 people as rural, in accordance with the standard used by the Rural Utilities Service, using a population-density measure as a safeguard against program abuse. Second, irrespective of population density, the Commission should consider defining areas with fewer than 20,000 people as rural if they have a health-care facility that meets the definition of a "community health center" or "critical access hospital." Third, the Commission should consider authorizing states to designate additional areas as rural based on unique circumstances that fall outside these general standards.

II. The Commission Can Address These Shortcomings by Expanding Its Definition of Rural To Include Additional Factors.

A. The Commission Should Consider the Definition of Rural Used by the United States Department of Agriculture's Rural Utilities Services Division.

In its *Further Notice of Proposed Rulemaking*, the Commission sought comment on whether there are any definitions of rural areas used by other government agencies or medical organizations that would be appropriate for the rural health care program.[14] I urge the Commission to consider, as part of its determination of what is "rural," the definitions used by the Rural Utilities Services (RUS) division of the United States Department of Agriculture (USDA).

Both the Commission's rural health care support mechanism and the USDA's RUS program share similar goals — to bring health care services and communications services to underserved areas. Accordingly, the Commission should consider adopting the USDA's definitions of rural as used by RUS in its broadband and telemedicine programs.

The RUS has two programs that provide funding for telecommunications and broadband services — the Rural Broadband Grant and Loan Program and the Telemedicine and Distance Learning Grant Program. Both of these programs should be considered as the Commission writes a new expanded definition of rural.

The Rural Broadband Grant and Loan Program of the Rural Utilities Service Division provides funding for rural areas in order to advance broadband connectivity in isolated, underserved areas. Under this program, the definition of rural is: "any area of

[14] *See Report and Order*, 18 FCC Rcd 24556 at ¶ 64.

the United States that is not contained in an incorporated city or town with a population in excess of 20,000 inhabitants."[15]

Until recently, this definition also required that the incorporated town *not* be located in a Metropolitan Statistical area (MSA).[16] The additional non-MSA requirement for eligibility drastically narrowed the number of communities eligible for funding under the program. Congress recognized this flaw in the definition and recently, in the 2004 Consolidated Appropriations Bill, repealed the non-MSA provision.[17] Accordingly, even communities that are a part of an MSA can qualify for Rural Utilities Service Broadband program funding if the population test is met.

By the same token, in the RUS Telemedicine and Distance Learning Grant Program (TDLT), an area is considered "non-urban" if it is within the boundaries of any city, village, or borough with a population of less than 20,000.[18] Notably, the TDLT program, like the Rural Broadband Grant and Loan Program, does not rely on MSA boundaries. The goals of the TDLT program are quite similar to those underlying the Commission's rural health care support mechanism. It provides funding for telemedicine facilities in

> areas that [RUS] believes have the greatest need for distance learning and telemedicine services. RUS believes that generally the need is greatest in areas that are economically challenged, costly to serve . . . . This program is consistent with the provisions of the Telecommunications Act of 1996 that designate telecommunications service discounts for . . . rural health care centers.[19]

While these analogous RUS programs provide a strong basis for moving beyond sole reliance on MSA boundaries, the Commission may want to include a safeguard to avoid moving from an underinclusive standard to an overinclusive one. For example, under the definition used in the RUS programs, a relatively large urban or at least suburban area — such as Falls Church, Virginia — could be eligible for funding, as long as its population is no more than 20,000.

Accordingly, I recommend that the Commission adopt the RUS's population-based standard, and a restriction based on population density. For example, the Commission's final definition of rural could include the following:

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[15] 7 U.S.C. 950bb(b)(2).
[16] *See id.* at 950bb(b)(2)(B)
[17] *See* Consolidated Appropriations Act, 2004, 108 Pub. L. 199, Division A, Title VII, Sec. 772, 118 Stat 3 (2004).
[18] *See* 7 C.F.R. § 1703.126(b)(2)(i) - (iv). The TDLT program lists several different categories of "rural," *e.g.*, an area is "exceptionally rural" if it is in a city of less than 5,000, and a "mid-rural" area is a city between 10,000 and 20,000. *See id.* Given the straightforward focus on "rural" areas in section 254(h), the Commission does not need to concern itself with degrees of "ruralness."
[19] 7 C.F.R. § 1703.101(b).

Any area that is not contained in an incorporated city or town with a population in excess of 20,000 inhabitants *and* does not have a population density higher than 250 persons per square mile.

B. Community Health Centers and Critical Access Hospitals Should be a Part of the Commission's Definition of Rural.

The universal service rural health support mechanism program is designed to provide access to telecommunications and broadband services in order to promote medical services to underserved areas. Federally designated community health centers and critical access hospitals are, by definition, entities that provide health services to needy communities. Accordingly, the Commission should consider whether an area has a community health center or a critical access hospital when determining its definition of rural.

A community health center is designated as such only if it is a "health professional shortage area."[20] The definition of rural should include areas that have a shortage of health services. However, an urban area can be considered a "health professional shortage area" so that distinction alone is not enough for an area to be designated as rural. There needs to be a qualifier in order to use the presence of a community health center as the basis for rural support. If a community health center component were bounded by the RUS's maximum population of 20,000, one could be assured that federal support would not be misdirected.

The Commission also should consider federally designated critical access hospitals as part of its definition of rural. A critical access hospital is only designated as such if it is located in a rural area is at least 35 miles (or 15 miles in mountainous terrain) from any other hospital.[21] The Commission should provide discounts to critical access hospitals, in addition to community health centers in an area with a population of less than 20,000, because of the rural nature of these hospitals.

C. The Commission Should Look to States As Further Insurance That Its Definition of Rural Is Adequate.

The Commission, at a federal level, is not as equipped as states to determine whether the demographics of a specific area qualify that area as rural or as a health professional shortage area. The state governments, on the other hand, have the expertise and established procedures for making such determinations.

No matter what definition the Commission adopts for rural, it is possible that certain areas that look rural, feel rural, and for all practical purpose, are rural, nevertheless do not, due to some unforeseen flaw, qualify as rural. There should be a fail-safe mechanism that protects these communities from falling through unanticipated cracks.

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[20] *See* 42 U.S.C. § 254(e).
[21] *See id.* at § 1395i-4(c)(2)(B)(i)(I).

A potential safeguard would be to allow state health-planning and development agencies to designate certain areas, or certain hospitals, as "rural" health providers. The state, which knows its owns demographics better than any other entity, could best determine what areas or hospitals are rural and underserved.

D. Proposed Final Definition

The Commission's new, expanded definition of rural should be based on established federal agency definitions of rural and should include a fail-safe mechanism to ensure that isolated, underserved areas are eligible for funding under the rural health care support mechanism program.

Accordingly, I propose the following definition, which incorporates all of the arguments set forth in these Comments. An area eligible for support under the universal service program would be:

1. any non-MSA county; or
2. any incorporated or unincorporated town, village, borough, or other area of fewer than 20,000 persons in a county with a population density of less than 250 persons per square mile; or
3. any incorporated or unincorporated town, village, borough, or other area of fewer than 20,000 persons that includes a community health center or critical access hospital; or
4. any community designated as rural by a state health planning and development agency.

This four-part definition guarantees that an area designated as "rural" will, in fact, include all areas that are isolated and underserved. I strongly urge you to adopt this definition. By doing so, the Commission will fulfill the goals of the universal service program, and the Commission will ensure that the goals announced in its recent *Report and Order* will be met.

Sincerely,

Rick Boucher
Member of Congress